HEALTH INSURANCE PREMIUM PAYMENT (HIPP)
FREQUENTLY ASKED QUESTIONS

1. WHAT IS HIPP?

The Health Insurance Premium Payment Program (HIPP) is a Medicaid program administered by the Department of Medical Assistance Services (DMAS) that may reimburse some or all of an enrollee's share of employer sponsored group health insurance premiums when it is determined to be cost effective for DMAS to do so.

2. HOW DOES A PERSON QUALIFY FOR HIPP?

- Be Medicaid eligible or have a Medicaid eligible child
- Have access to a group health plan or COBRA through an employer
- Meet DMAS cost effectiveness test

3. HOW DOES DMAS DETERMINE COST EFFECTIVENESS?

The cost of the insurance premium is compared to the cost for Medicaid to insure an individual of similar age and gender under one of the Medicaid Managed Care programs, and takes into consideration the area of the state where the Medicaid eligible individual resides. These are known as HIPP capitation rates and change periodically based on recipient changes in age, aid category or the locality in which an enrollee resides.

4. WHO IS ELIGIBLE FOR HIPP?

For some persons, enrollment in the HIPP program is mandatory. As a condition of Medicaid eligibility, any person who is eligible for Medicaid, is a member of an assistance unit which contains an individual employed more than 30 hours per week, and is eligible for coverage under an employer's group health plan must complete the HIPP Application Form and the Medical History Questionnaire, and submit the Insurance Verification Form to the employer. If DMAS determines that enrollment of the person in the group health plan is cost-effective; the person must enroll in the group health plan in order to remain eligible for Medicaid. Individuals whose enrollment in the HIPP Program is not mandatory, but who meet the requirements in #2, and are interested in keeping their family on one insurance policy may wish to consider the HIPP Program. In addition, Medicaid may pay for some services not covered by the group insurance, including co-pays and deductibles. HIPP will reimburse a person for his/her share of the cost of the health insurance premiums or a portion thereof depending on the DMAS cost effectiveness evaluation.

5. HOW DOES A PERSON APPLY FOR THE HIPP PROGRAM?

If a family member is employed and has access to an employer sponsored group health insurance plan, an applicant is required to complete a HIPP application when Medicaid is initially applied for or during any subsequent reviews of eligibility. A person can contact his/her local department of social services office to obtain an application.

6. WHAT ARE THE HIPP APPLICATION REQUIREMENTS?

The HIPP application consists of three sections that must be completed. The first section asks for personal information: name, address, social security number, employment and names of family members. The second section is a Medical Questionnaire that asks questions about the medical history of Medicaid eligible family members who are covered under your group policy. The third section is an Employer Insurance Verification form. This is to be filled out by the employer and provides information about available group insurance. The completed application is to be returned to your local DSS case worker who will send it to DMAS.

7. WHAT ARE THE APPLICATION PROCESSING AND NOTIFICATION REQUIREMENTS?

Upon receipt of a person's HIPP application, DMAS has 45 days to process the application and send the applicant a decision letter. All three sections of the application must be submitted in order for the application to be processed. An approval letter detailing the process, amount of the check and other important program information is sent upon approval of the HIPP application. If the application is denied, a denial letter is sent explaining the reason for the denial and giving the applicant appeal rights.

8. WHEN/HOW WILL REIMBURSEMENT BE MADE?

If a person is found eligible and enrolled in the HIPP Program, reimbursement will begin the month after the person is approved for the program. On the last Friday of every month a check is sent via the U.S Postal Service reimbursing the person for the approved HIPP amount. This amount is designed to assist the enrollee with insurance premium costs associated with active enrollment in an employer's group insurance plan for the Medicaid eligible person(s) in his/her household. This check should be received after the first day of the next month following initial enrollment in the program.

9. WHAT ARE THE REQUIREMENTS TO REMAIN IN THE HIPP PROGRAM?

- Send a copy of the most recent pay stub **every month** showing the deduction for the health insurance premium. A return postage paid envelope will be provided for this purpose. If you don't send in a pay stub, the HIPP case may be suspended or terminated.
- Notify the HIPP Unit immediately if employment terminates or changes. You are no longer eligible for the HIPP program if employment terminates. If employment and/or insurance coverage changes, a re-evaluation must be completed by DMAS to determine continuing eligibility in the HIPP program.
- Notify the HIPP Unit immediately of any address changes. HIPP checks cannot be forwarded via the postal service so it is critical to report address changes to both the HIPP Unit and the local DSS office as soon as possible. In the event a person has moved and has not notified his/her local DSS office, the check will be returned to DMAS and could result in a delay in getting the check or cancellation from the HIPP program.

10. WHAT HAPPENS IF PAYSTUBS ARE NOT SUBMITTED EVERY MONTH?

- The first month the HIPP Unit does not receive a pay stub, a check will be sent as well as a reminder to send in pay stubs.
- The second month the HIPP Unit does not receive a pay stub, the person's case will be suspended and a check will not be sent.
- The third month the HIPP Unit does not receive a pay stub, the person's HIPP case will be cancelled. A new HIPP application will have to be submitted and re-evaluated to receive reimbursement for his/her premiums. There will not be any retroactive reimbursements made as a result of this action.

11. WHAT IF MEDICAID COVERAGE IS CANCELLED?

A person should contact his/her local Department of Social Services to find out the reason for the cancellation and if Medicaid coverage can be reinstated. He/she also needs to contact the HIPP Unit to let them know Medicaid coverage was cancelled. In many cases, cancellation of some of the family members does not mean cancellation from the HIPP Program but it may result in lower premium reimbursement, especially if the amount of your reimbursement is based on HIPP capitation rates

12. WHAT IF A PERSON HAS ADDITIONAL QUESTIONS ABOUT THE HIPP PROGRAM?

A person should contact his/her local department of social services office if there are any additional questions about the HIPP Program.